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CASE NOS.: **2004-LHC-1119**
2004-LHC-1120
2004-LHC-2056

OWCP NOS.: **18-75523**
18-75524
18-66483

IN THE MATTER OF

ZANDRA ENNO,
Claimant

v.

MCCS/U.S. MARINE CORPS,
Employer

APPEARANCES:

David Utley, Esq.
On behalf of Claimant

Christopher M. Galichon,
On behalf of Employer

BEFORE: C. RICHARD AVERY
Administrative Law Judge

DECISION AND ORDER

This is a claim for benefits under the Longshore and Harbor Worker's Compensation Act, 33 U.S.C. 901 et seq., (The Act), brought by Zandra Enno

(Claimant) against MCCS/U.S. Marine Corps (Employer). The formal hearing was conducted in Minot, North Dakota on July 21, 2004. Each party was represented by counsel, and each presented documentary evidence, examined and cross examined the witnesses, and made oral and written arguments. The following exhibits were received into evidence: Joint Exhibit 1, Claimant's Exhibits 1 through 20, and Employer's Exhibits 1 through 25. This decision is based on the entire record.[1]

Stipulations

Prior to the hearing, the parties entered into joint stipulations of facts and issues which were submitted as follows:

1. The injuries/accidents occurred on August 31, 1997, March 20, 2001, and March 23, 2001;
2. The August 31, 1997 and March 23, 2001 injuries/accidents were in the course and scope of employment, and the March 20, 2001 accident is disputed;
3. An employer/employee relationship existed at the time of the injuries/accidents;
4. Employer was timely advised of the injuries/accidents;
5. Notices of Conversion were timely filed;
6. An informal conference was held on February 18, 2003;
7. Medical benefits have been paid;
8. The date of maximum medical improvement for Claimant's August, 1997 injury is April 13, 1999. Other dates of maximum medical improvement are disputed.

Issues

The unresolved issues in this proceeding are:

1. Nature and extent of disability;
2. Average weekly wage and benefit rate;
3. Loss of earning capacity;
4. Future medical benefits; and

[1] The following abbreviations will be used throughout this decision when citing evidence of record: Trial Transcript pages: "Tr. __"; Joint Exhibit: "JX _, p. _"; Claimant's Exhibits: "CX _, p. _"; Employer's Exhibits: "EX _, p. _."

5. Attorney's fees and costs.[2]

Statement of the Evidence
Testimonial and Medical Evidence

Claimant is a divorced 52 year old mother of four. Her children are 38, 37, 35, and 19; the youngest child lives with her. Claimant was born on the Turtle Mountain reservation in North Dakota. As a member of the Chippewa tribe, Claimant attended school on the reservation, elementary school at St. Ann's Mission school and began Turtle Mountain High School but dropped out in the seventh grade. Claimant stated that she cannot read or spell well and cannot do math. (Tr. p. 61).

Claimant testified that she has possessed a variety of jobs over the years, housekeeping being the most common. Her first job was as a housekeeper at local hospitals in North Dakota. She also worked as a barmaid. In Texas, she worked as a cashier at a gas station, as a caterer's helper and deli worker for a company which provided food service to college students, and as a housekeeper at a retirement home. She also worked as a housekeeper at Shepard Air Force Base in Texas.

Claimant eventually relocated to California where commencing December 11, 1996, she was employed by Respondent USMC as a housekeeper at Camp Pendleton. During this period, Claimant held an additional job as a cashier at Target from March 1997 through August 1997. Claimant stated that her job at Target consisted of working on the floor, folding clothes and returning items to shelves. She was eventually allowed to cashier, which she stated she had no trouble with because everything was computerized so that all she had to do was scan items, she did not have to perform any calculations in her head.

Claimant held the housekeeping position at Camp Pendleton for almost a year until she sustained an occupational injury on August 31, 1997. While working, Claimant suffered back pain and received medical treatment from Camp Pendleton's occupational health center. She was diagnosed with an L4-L5 lumbar strain and eventually a laminectomy was performed on the affected areas.

Claimant testified that she returned to the housekeeping position on a light duty basis following the injury; and after the back surgery, she returned to work on

[2] Although not raised at trial, Employer in its post-hearing brief raised 8(f). The issue is mooted, however, by the order entered in this decision. Claimant was not found to have 104 weeks of permanent disability.

a light duty basis as a front desk clerk at Camp Pendleton, a job which was approved by Dr. Tung, her treating physician. Claimant stated that this position involved attending to customers who were staying in "billeting services," which is the equivalent of a hotel. Claimant testified that in performing the job, she was required to spell and write, such as when she had to make reservations or check in a guest. She also stated that the position required her to use a computer to make such entries, which she had no previous experience with. Claimant stated that she received some computer training, but only because a new system had been installed, so every staff member had to be trained on the new computers.

Claimant testified that the desk clerk job was emotionally and physically challenging for her. She stated that one of the two buildings she worked at had no place to sit down at the front desk. Claimant testified that she complained to the supervisor that she was not supposed to stand for long periods of time, and was told that she should take breaks when she needed to, but Claimant stated that she felt like she could not take breaks when there was a line of customers waiting to check in and no one to assist her. Claimant also stated that before one building had a voice mail system, she was required to deliver messages to guest's rooms, though she was not supposed to be climbing stairs.

Claimant recalled incidents where she had to take down a phone message by hand, which was hard for her, and stated that other employees laughed at her, telling her they could not understand what she had written. She also stated that it took her longer to perform tasks than other workers, and she felt humiliated when there was a line of guests waiting to check in and she had to enter their information in the computer by means of typing with one finger. Despite her feelings about the job, she stated that she had no choice but to continue working there because she had to make a living.

Claimant testified that while working as a desk clerk, she had trouble with her back on several occasions. She stated that if she climbed stairs, or sat or stood for too long, her back would "lock up," causing her a great amount of pain. She stated that she would have to lie over a desk in order to relieve the pain.

Claimant noted that she began having problems with her hands while in the desk clerk position. She stated that she began getting "lumps" between her fingers, pain shooting into her shoulders, and numbness in her fingers. She stated that she told supervisor Monique Ramirez of these problems, who in turn told Claimant to finish work that day and sent Claimant to the occupational health office the following day. She eventually had a consultation with Dr. Mikulics for problems

relating to her hands, and he determined that Claimant had carpel tunnel syndrome. Claimant stated that she was supposed to have testing performed on her wrists but she never did so because she subsequently moved away from California.

Several days after she visited occupational health for her hand problems, Claimant testified that she fell at work. She stated that on March 23, 2001, she was supposed to have taken a break but could not because all the other employees were at lunch. As a result of not taking a break, Claimant testified that she sat in a chair all morning waiting on customers, and she could feel her back tensing up. Claimant stated that she knew she needed to take some medicine for her back. The medicine was located in her truck. In order to get to the truck, Claimant had to descend some steps, and in the process, when she lifted her leg, "it went dead," resulting in her falling and landing with one leg underneath her.

Claimant was transported by ambulance to the base hospital where she was examined and she later saw Dr. Tung, who Claimant states told her that she had reinjured her back in the fall and recommended a fusion. Claimant stated that Dr. Tung informed her of all of the possible risks and consequences of the procedure, but told her that she would have to have it done eventually. Claimant stated that she decided to have the procedure, and even went so far as to schedule it.

The procedure was never performed because Claimant moved back to North Dakota some time in the summer of 2001. When residing in California, she had lived with her daughter's father, Tom, who was a Marine. Claimant stated that unbeknownst to her, Tom had planned to go overseas for some time and had put in for a transfer. She stated that Tom told her that he was going to Okinawa and Claimant was not going with him. She testified that he drove Claimant and her daughter to Minot, North Dakota where he boarded a plane for Okinawa. Claimant stated that while Tom did not require that she and her daughter return to Minot, she had no choice but to return because she could not afford to stay in California and she had family in Minot that could help provide for her.

Upon her return to Minot, Claimant initially saw Dr. Stillerman. She told him she had been scheduled for a fusion in California and brought her MRIs to show him. Claimant testified that Dr. Stillerman said that he "wouldn't touch" Claimant, but instead would send her to the Mayo Clinic in Minnesota. Claimant stated that though she was leery of the surgery due to the risks Dr. Tung had explained, she decided to have the surgery, but could not remember why it was never performed.

Claimant saw Dr. Lee in Minot for treatment of her hand problems. Claimant stated that she had carpel tunnel syndrome and that Dr. Lee's treatment consisted of wearing braces at night which Claimant did not do because she could not afford to purchase the braces.

Claimant also saw Dr. Reeve in Minot who suggested that she attend a pain management program. Claimant enrolled in a three-week program at Tri-Life Center, which she stated was the best thing that ever happened to her because she learned techniques to help her cope with her pain, as well as reduce anxiety and stress. Claimant also regularly saw Dr. Dillas for treatment of other medical problems such as diabetes and a heart condition.

Claimant testified that her back is currently troubling her. She stated that it is "always tight" and she has constant gnawing pain. She also stated that her right leg "goes dead" if she sits too long, and that she has spasms in both her legs when she lies down, or sits or stands for too long. She stated that she has difficulty sitting, that she was having a hard time sitting for the hearing, she can't bend or twist at the waist.

Claimant stated that her hands still trouble her as well, stating that when she talks on the telephone, her hand will "go dead" within 15 minutes. She also complained of numbness and shooting pain in her right arm. She stated that these symptoms are better some days than others. Claimant also stated that she has problems with incontinence.

Claimant testified that she would like to return to work if she can. She stated that she did not think she could perform the desk job with the Marine Corps because her back locked up so frequently there. Nor did she think she could return to the job at Target because she would be required to stand for the shift. Claimant last received worker's compensation benefits in February 2003. She testified that she has not been able to support herself since that time and has had to leave her home and sell her furniture. She stated that she buys groceries with food stamps and has been receiving public assistance since her benefits ceased.

On cross-examination, Claimant recalled an aptitude test administered by Ms. Amy Wise, and admitted that her then-companion Tom was in the room while she took the test and that she asked Tom for help in answering questions. Claimant testified that she did this when Ms. Wise was not looking. Claimant testified that there was never any disciplinary action taken against her regarding her job performance. She also stated that Tom paid for her relocation expenses to Minot.

Claimant was asked why Dr. Reeve's records indicated that she refused a spinal fusion surgery and she stated that she could have declined.

Bonnie Sjol, R.N.

Ms. Sjol testified that she is a registered nurse certified in psychiatric nursing, and the center director and owner of Tri-Life Center pain management program in Minot, ND. Ms. Sjol stated that Tri-Life differs from a standard pain clinic because it utilizes a multidisciplinary approach provided by a treatment team consisting of a psychiatrist, neuropsychologist, physical therapist, nurse practitioner, and Ms. Sjol. Tri-Life is the only facility in North Dakota that is accredited by the Commission and Accreditation of Rehabilitation Facilities in chronic pain management, and is one of 29 in the world to have such accreditation.

Ms. Sjol stated that the Center's procedure consists of a client being referred by a physician, whereupon a two-day evaluation is completed by the treatment team. Claimant's evaluation was completed in January 2003, and it was recommended that Claimant attend the three-week outpatient pain management program. This recommendation was accepted by Employer.

Ms. Sjol described the treatment that Claimant received in the program as consisting of physical therapy, hydrotherapy and tai chi, as well as an educational component focusing on non-pharmacological pain management, relaxation skills and imagery. Ms. Sjol testified that after the three-week program, there are six follow-up visits over the course of a year following completion of the program.

Ms. Sjol testified that during her evaluation, Claimant exhibited symptoms of chronic pain behavior including guarding, moaning, groaning, rubbing, holding, frequently getting up from her chair and sitting back down, facial grimacing, and pain talk. Ms. Sjol stated that Claimant also displayed a very flat sad affect and was tearful at various times during the interview. Ms. Sjol stated that Claimant was provided with the routine treatment above, as well as stress management and a home exercise program.

Ms. Sjol stated that Claimant did not do as well as the treatment team hoped in terms of comprehending material. For example, clients are required to keep a journal, and Ms. Sjol testified that Claimant was not able to complete this task. Ms. Sjol stated that Claimant had difficulty retaining information. For this reason, it was suggested that Claimant repeat the three-week program, which she did. Ms.

Sjol stated that Claimant performed better in the second program but her comprehension skills continued to impair her progress.

Ms. Sjol stated that when Claimant was last evaluated at the facility on February 17 and 18, 2004, she was still exhibiting pain behaviors. She testified that the program had difficulty obtaining authorization from the insurance carrier for Claimant's follow-up visits, that claims adjuster Tracie True sent correspondence to Tri-Life stating that nothing was approved past the three-week program.

Finally, Ms. Sjol stated that in the initial evaluation process, the treatment team at Tri-Life assesses patients for symptoms of malingering, including administration of tests by the neuropsychologist. Ms. Sjol stated that through her interactions with Claimant, she opined that Claimant was not malingering because "she wouldn't have those cognitive abilities to potentially and maliciously go about living her life."

Ms. Sjol stated that the treatment team recommended a psychiatrist to manage Claimant's medications, outpatient psychotherapy, and attending an adult partial hospitalization program. She stated that none of these recommendations were authorized by the insurance carrier. The team also recommended that Claimant attend the adult learning center in Minot to work on her basic reading skills.

On cross-examination, Ms. Sjol stated that her only training in vocational rehabilitation was on the job training, and that Tri-Life did not have a vocational expert on staff. She conceded that the records reflected the reason for Claimant needing to repeat the Tri-Life program was due to her own personal life stressors, but added that her learning difficulties were another reason repetition was necessary. Ms. Sjol, however, could not point to anything in the record which supported her statement that Claimant needed to repeat the program because of her learning difficulties. Ms. Sjol stated that Claimant was referred to Tri-Life initially for occupational injuries but because the program has a holistic focus, they provided treatment for her other diagnoses as well. She additionally stated that aside from correspondence sent to the insurance carrier's claims adjuster, there was nothing in the original request for authorization pertaining to the six follow-up visits.

On redirect examination, Ms. Sjol identified Claimant's personal stressors that she was aware of as including being cut off from benefits and having no

income, being in a turbulent relationship, and being depressed and anxious from these occurrences.

Dr. Gregory Peterson

Dr. Peterson testified that he is a physician specializing in physical medicine and rehabilitation employed by MedCenter One Health Systems in Bismarck, ND, since 1996, and is an associate professor of medicine at the University of South Dakota. He stated that he was formerly the medical director of the Mayo Clinic Spine Center.

Dr. Peterson evaluated Claimant twice, reviewed medical documents and rendered two reports. In his examination of Claimant, Dr. Peterson testified that he performed several physical examination tests on her, including the straight leg-raising test which involves the patient either sitting or lying down and the physician straightening the patient's leg. Dr. Peterson stated that when he performed this test in June 2004, Claimant's seated straight leg-raising was 80 degrees bilateral with no complaints of pain. He stated that in the supine position, Claimant complained of buttock and thigh pain at 45 degrees of straight leg-raising on the left. From these results, Dr. Peterson testified that he concluded that this indicated a sign of inconsistency and an indication that the patient may be consciously or unconsciously exaggerating her symptoms of pain.

In addition, Dr. Peterson testified that there are a number of other ways to test for inconsistency, the most common being Wadell's Signs. Dr. Peterson testified that Claimant's examination was positive for all five Wadell's Signs. Dr. Peterson stated that Claimant's subjective complaints were significantly out of proportion to the objective findings he observed in reviewing her medical records, x-rays, and physically examining her.

Dr. Peterson testified that based on his evaluations, Claimant did not need any current active care or future care for her work-related injuries. He stated that when he last examined her she was still participating in hydrotherapy at Tri-Life center and Dr. Peterson opined that further hydrotherapy was unnecessary. He also stated that he saw no objective findings that would suggest that Claimant would have any further problems related to her arms or her spine. Dr. Peterson testified that in his review of records and examination of Claimant, there was no objective evidence that would suggest that Claimant has neurogenic incontinence.

Dr. Peterson discussed two nerve conduction studies that were performed in 2001 and 2004. The first study had a normal result, but the second was interpreted by Dr. Lee as establishing mild carpal tunnel syndrome on the right side and borderline on the left. Dr. Peterson stated that there was no way for him to tie the carpal tunnel syndrome to a work-related injury because the test performed at the time of Claimant's alleged injury was normal, but subsequent testing three years later exhibited minor abnormalities. Dr. Peterson stated that a diagnosis of diabetes could play a part in a diagnosis of carpal tunnel syndrome because it makes the nerves more susceptible to pressure neuropathies.

Dr. Peterson testified that at the time of his April 2002 evaluation, he was of the opinion that Claimant was capable of being employed. This opinion did not change after Dr. Peterson completed his second evaluation. Dr. Peterson reviewed and approved several positions for Claimant, including cashier, lodging clerk, front desk clerk, and sewing machine operator. Dr. Peterson stated that he believed Claimant was capable of performing the approved jobs 40 hours per week, the only restriction being the degree of stooping and bending.

Dr. Peterson testified that he found Claimant to be permanent and stationary at the date of his initial evaluation of her, April 2002. He stated that the main difference he found in the two evaluations of Claimant was that in the June 2004 visit, Claimant demonstrated less pain behavior compared to the first evaluation.

Dr. Peterson stated that when he refers a patient to any type of pain management program, the primary goal is to assist the patient in coping with their pain problems more effectively. The secondary goal is some kind of return to gainful employment. Dr. Peterson stated that in Claimant's case, the secondary goal was not reached, and from his review of the records, he opined that this failure was due to several factors including psychosocial stressors, continued complaints of pain, lack of a health care provider to encourage her to function at a higher level or return to work, and other medical and psychological conditions unrelated to her occupational injuries.

Dr. Peterson testified regarding the standard for recommendation of a spinal fusion procedure. He stated that standards vary, but the traditional well-accepted standards are slippage of one vertebra on the other or if the patient has x-rays showing excessive movement "showing forward and back, or pressure on the nerves that result from movement forward and back of the spine." He stated that the less clear indications are a completely elective procedure for the treatment of pain which is very controversial. Dr. Peterson reviewed two surgical opinions

found in Claimant's records. Using the traditional standards above, he opined that Drs. Tung and Stillerman both recommended the fusion procedure for the treatment of Claimant's pain.

Dr. Peterson testified that there were contraindications for performing a fusion on Claimant because she is a smoker and they have a much lower success rate with elective fusions. He also stated that patients who demonstrate abnormal illness or pain behaviors have much lower degrees of success with elective fusions. Finally, he stated that Claimant's other medical problems would be relative contraindications and concerning factors. Dr. Peterson testified that there is no such thing as "waiting too long" to have an elective fusion for the treatment of pain.

In his review of medical records and examination of Claimant, Dr. Peterson could find no evidence which supported complaints of bilateral leg numbness from the kneecap and below. He stated that the most common explanation for such a condition is peripheral neuropathy, which affects the long nerves. It is caused by numerous medical conditions, but most frequently by alcohol abuse and diabetes. He stated that none of the conditions causing peripheral neuropathy would be explained by Claimant's work-related injury. He stated that there was no evidence to support a finding of lack of ability to engage in sexual relations.

On cross-examination, Dr. Peterson testified that there are physical examination maneuvers which are effective in diagnosing carpal tunnel syndrome. He stated that one of these maneuvers, the Tenels test, should be a basis, but not the sole basis for a diagnosis of carpal tunnel syndrome. He further stated that pin-prick tests are used to make such a diagnosis, but it has been proven to be a fairly poor way to determine whether carpal tunnel syndrome is present. Regarding Dr. Lee's report which could not ascertain whether Claimant had carpal tunnel syndrome or overuse strain, Dr. Peterson stated that repetitive keyboard activities were a type of activity that could cause an overuse strain injury.

Dr. Peterson further testified on cross-examination that he diagnosed Claimant with chronic pain syndrome in April 2002, and that he believed that the treatment she received at Tri-Life was reasonable and necessary. He also stated that Tri-Life's recommendation of a physician to monitor Claimant's prescription drug intake was reasonable. When asked about his use of the term "dramatic" in describing Claimant's behavior during the exam, Dr. Peterson conceded that such behavior is not uncommon in patients with chronic pain syndrome, and he was

aware that dramatization was one of the AMA Diagnostic Criteria for chronic pain syndrome.

On redirect examination, Dr. Peterson stated that based upon his review of the records and examination of Claimant, a front desk clerk position including no bending, stooping, lifting greater than ten pounds, no prolonged sitting or standing, with the ability to sit or stand at will that consisted of some keyboarding, answering phones and some handwriting would be appropriate employment for Claimant.

Monique Ramirez

Monique Ramirez testified that she was currently the director of the Camp Pendleton Billeting Fund and had been in that position for a few months, but was formerly the finance personnel manager of the Camp Pendleton Billeting Fund, a position she held over eight years. In that position, Ms. Ramirez was responsible for overall management of all personnel and human resource aspects of the department.

Ms. Ramirez testified that Claimant was not an employee in her section, but she was familiar with Claimant. She stated that after Claimant's first injury, Ms. Ramirez constantly monitored her to make sure she was alright and that Claimant's supervisors were meeting her needs. Ms. Ramirez described Claimant as a good employee. She stated there were no problems with Claimant in either the housekeeping or front desk clerk positions. Ms. Ramirez stated that Claimant was friendly, a hard worker, and never had disciplinary action taken against her.

Ms. Ramirez described the front desk clerk position as consisting of some typing which involved minimal computer skills, answering phones, customer relations, and dealing with guests in person. There were no lifting requirements. Claimant was able to sit and stand at will at both of the facilities. Ms. Ramirez stated that Claimant was able to take breaks as often as she needed. She further stated that Claimant never complained to her about an inability to sit for long periods of time.

Ms. Ramirez testified that Claimant was not required to do any stair climbing in order to deliver phone messages to guests. She also stated that Claimant never complained to her about having to climb stairs, and Ms. Ramirez never observed Claimant climbing stairs to deliver messages from her office a couple of doors down from the front desk

Ms. Ramirez stated that she monitored Claimant's work and found it acceptable. She stated that Claimant was able to answer phones and do customer service. She testified that Claimant was apprehensive about her computer skills, but she understood her duties and was "going to be okay." Ms. Ramirez stated that Claimant was also apprehensive about her typing skills, but was offered a software program to assist her in typing to use at her convenience, and Claimant had stated that she was getting better.

Ms. Ramirez stated that Claimant's front desk job was currently available 40 hours per week. She stated that if Claimant had not left the job, there would have been anticipated pay raises so that current rate for the position was about $8.50 per hour.

Ms. Ramirez recalled when Claimant informed her she was having problems related to her hands. Ms. Ramirez stated that she told Claimant if Claimant thought it was serious, Ms. Ramirez would fill out the forms necessary for Claimant to be examined by a physician. She also stated that during early 2001, Claimant visited Ms. Ramirez and told her that there were things going on in her personal life and that she was trying to prepare herself for the future and she thought the best thing to do for herself and her daughter was to move back to North Dakota.

On cross-examination, Ms. Ramirez was asked if she could explain why Ms. Amy Wise, a vocational rehabilitation counselor, reported that she contacted Camp Pendleton on May 17, 2004, and was told that there were no appropriate positions for Claimant. Ms. Ramirez stated that Ms. Wise would not have contacted her office, but probably contacted the Marines and Contract Claims personnel office which handles workers compensation claims.

Joyce Gill, M.Ed.

Joyce Gill testified by means of deposition on July 13, 2004. Ms. Gill is a certified rehabilitation counselor and has held this position for 28 years. She was retained by the U.S. Department of Labor to provide vocational rehabilitation services to Claimant. Ms. Gill met with Claimant to conduct an assessment on June 22, 1999. As part of the assessment she reviewed medical reports which stated that Claimant was precluded from heavy work, but Claimant's self-described limitations were far more restrictive than what the doctor indicated in the report.

Ms. Gill testified that Claimant stated that she worked for three months at Target and gave no indication that she was unable to perform that job, nor any indication that she did not have the mental acuity to perform the job at Target. Ms. Gill reported the same finding about Claimant's employment with the Aramark Corporation as a deli worker and caterer's helper and cashier.

Ms. Gill administered several tests to Claimant in order to assess Claimant's ability to solve abstract problems, word-picture association, word decoding, phrase and sentence comprehension and paragraph comprehension, and addition, subtraction, multiplication and division of whole numbers, fractions, percentages and decimals. In addition, Ms. Gill administered a Wide Range Achievement Test which measures codes required to learn basic skills like reading, math, and spelling. She also gave Claimant an interest inventory which assesses interest levels in various types of occupations.

Ms. Gill testified that she was present when the tests were actually administered to Claimant and that Claimant did not have any assistance in completing the tests. The only test item that Ms. Gill was not present for was the interest inventory, which she stated is not really a test but an assessment tool. Ms. Gill stated that Claimant may have talked about the items on this inventory with her boyfriend, because this item was given to Claimant with instructions to mail it to Ms. Gill's office when completed.

Ms. Gill stated that on the Raven test, which measures ability to solve abstract problems, Claimant scored in the 60th percentile, which demonstrated that she was within the intellectually-average range. On the reading test, Claimant was proficient in picture-word association, word decoding, phrase comprehension, and sentence comprehension, but her score in paragraph comprehension was deficient. On the arithmetic test, Claimant was proficient in addition and subtraction of whole numbers, but was deficient in multiplication and division of whole numbers, fractions and percentages. Ms. Gill opined that Claimant's math scores showed that she would be able to perform a cashier job because cashiering involves mainly addition and subtraction. Based on the overall testing, Ms. Gill concluded that Claimant was best suited for occupations which would enable her to learn on the job through hands-on demonstration as opposed to going through a training program that would require academic preparation.

Ms. Gill stated that when the alternative job of front desk clerk was identified by Employer, and this job description was sent to Dr. Tung, Claimant's initial response was that she did not want to go back to work, but wanted to go to

school, specifically, to an electronics assembly program that had been identified by Ms. Gill. She said that Claimant expressed a desire to obtain her GED and never indicated to Ms. Gill that she did not possess the mental acuity to do so.

On cross-examination, Ms. Gill stated that the only information that she had regarding the appropriateness of the desk clerk position in terms of its physical requirements was the representation she received from Employer that Claimant was performing her job adequately. She stated that she never talked to Claimant after she went back to work because Claimant never returned any of Ms. Gill's phone calls.

The records from occupational health at Camp Pendleton comprise Claimant's Exhibit 15. The first record of Claimant visiting occupational health is an entry on July 3, 1997, listing date of injury as June 28, 1997. The record states that Claimant strained her mid lower back by transporting linen, equipment, and supplies to the lower level. Claimant was put on "no work" status for both her housekeeping and cashier jobs, but at a follow-up appointment on July 9, 1997, Claimant was released to moderate duty at both jobs. On July 16, 1997, the treating physician included restrictions that Claimant could not lift in excess of 10 pounds or perform repetitive lifting twisting, working above shoulders, or repetitive use of upper extremities.

Records pertaining to Claimant's August 31, 1997 injury indicate that she was first seen at occupational health for that incident on September 5, 1997 where she complained of pain in her right leg and tickling and numbness in her toes. Claimant was diagnosed with lumbar strain, rule out disc disease. She was treated with Motrin and Flexeril and told to rest at home. She was taken off work from both her jobs from September 5 through September 10. Claimant returned for a follow-up visit on September 8, where the record states she was treated for lumbar strain. On September 10, the notes state that the occupational injury was "lumbar strain—new injury with radiculopathy and thoracic strain—old injury." Claimant was instructed to continue Motrin, Flexeril and moist heat to her back.

Claimant returned to the clinic on September 15 and 18 where the prior course of treatment was continued by the clinic physician. On September 24, the clinic physician's diagnosis was lumbar strain with L5 radiculitis. The treatment plan consisted of the prior course of treatment with the addition of scheduling an MRI. At Claimant's September 30 visit, the record indicates that the MRI was performed, showing positive results of bulging L4-L5 disc onto the L5 nerve root.

Claimant next saw Dr. Stephen P. Nichols, an orthopedic surgeon. His records are found at Claimant's Exhibit 14. Dr. Nichols first saw Claimant on December 5, 1997, where her chief complaints consisted of low back pain with associated stiffness and right lower extremity pain with numbness and tingling. The record indicates that Claimant stated that activities such as lifting, carrying, bending, stooping, squatting, pushing and pulling, in addition to prolonged walking, sitting or standing, all exacerbated her pain. She did not feel ready to return to work as of this visit with Dr. Nichols.

Dr. Nichols reviewed Claimant's MRI of September 30, 1997 and conducted a physical examination. He diagnosed Claimant with low back pain with extension to the right lower extremity and opined that the occupational injury was causative for Claimant's condition. Dr. Nichols stated that he did not think Claimant was totally disabled, he believed she could work with modification. He stated that Claimant could return to modified work from 12/5/97 to 12/30/97 with the following limitations: standing, walking, bending, stooping, climbing, not lifting, carrying, pushing or pulling more than 10 pounds.

Claimant saw Dr. Nichols again on 12/18/97 where an electromyogram and right sural nerve conduction study were performed. Dr. Nichols concluded that there were nonspecific findings in the right lumbar paraspinal muscles suggestive of muscle spasm or myofacial irritation, however, there was no definitive electrodiagnostic evidence of lumbosacral radicuopathy, as evidenced by the report of Dr. Blake Thompson who performed the electrodiagnostic evaluation (EX 11). Dr. Nichols stated that the MRI revealed problems referable to the low back, but with nerve compression on the left, but Claimant was complaining of pain to the right, so he recommended further studies including a CT myelogram. He continued Claimant on modified work duty with the same restrictions.

Dr. Nichols saw Claimant again on 2/2/98, after the CT myelogram was completed. He stated that Claimant continued to complain of pain to her right lower extremity, but since the CT myelogram showed, as did the previous MRI, evidence of disc disease but with compression of the nerve roots involving the lower left extremity, Dr. Nichols stated that he was at a loss to the direct cause of Claimant's symptoms and thus referred her to Dr. Ted Georgis for a second opinion of the disease process. Dr. Nichols kept Claimant on modified work duty, but altered the restrictions so that her limitations were limited bending and stooping, climbing, no lifting, carrying, pushing or pulling carrying over 20 pounds, and no prolonged sitting less than 20 minutes.

On March 2, 1998, Claimant returned to Dr. Nichols after her appointment with Dr. Georgis. Dr. Nichols' notations state that neither he nor Dr. Georgis felt that Claimant was a strong surgical candidate. At this visit, Claimant stated she was in so much pain that she did not get out of bed. Dr. Nichols concluded that Claimant did have lower lumbar degenerative disc disease, and he felt that the best option for her was spinal stabilization and epidural steroids. Claimant began receiving epidural steroid injections from Dr. Eric Wardrip at Health South Center for Surgery of Encinitas on March 9, 1998, whose records comprise Claimant's Exhibit 12. Dr. Nichols also wanted Claimant to work with modifications because he felt that being active was in her best interest and was part of the healing process.

On March 13, 1998, Claimant went to the emergency room at Tri-City Medical Center complaining of back pain. This record is found at Claimant's Exhibit 13. The visit occurred on her first day back at work when she had cleaned mirrors and folded sheets. She stated that pain was radiating down her leg, she was getting no relief from Vicodin, and the epidural injections she was receiving were not helping. She was given pain medication and a work release that she was not to work until she had her next epidural injection.

On her second visit to Dr. Wardrip for epidural injections on March 16, 1998, Claimant complained of an increase of back pain radiating into both legs following her first injection, and told Dr. Wardrip of her emergency room visit. Dr. Wardrip gave Claimant another injection and noted that if Claimant had no positive response to it, he would question the need to perform a third. Claimant returned on March 24, where she reported mild relief from pain following the second injection. Claimant stated she had been trying to avoid activities which strain her back but she did note that she had back pains after coming home from work. Claimant was given a third injection, but complained of a headache shortly after the procedure. On March 26, Dr. Wardrip saw Claimant again because she complained of the headache continuing for two days. Dr. Wardrip noted that during the procedure Claimant suffered an inadvertent dural puncture and since that time complained of a severe global headache as well as a posterior neck ache. Dr. Wardrip excused Claimant from work for the period of March 24, 1998 to April 3, 1998 and returned her to limited duty, no lifting, bending or climbing.

Dr. Nichols received the job description of housekeeper which had been designated light duty. He determined that Claimant could perform the job. Claimant's restrictions were subsequently modified on April 3, 1998 to include limitations on bending and stooping, climbing, and lifting, carrying, pushing or pulling 10-15 pounds. At the April 3 visit, Dr. Nichols recommended 12

chiropractic visits with Dr. Victor Tomassetti. Dr. Nichols stated that if this did not work, Claimant had only two options remaining: living with her pain or undergoing surgical intervention in the form of decompression and/or fusion. Claimant's last visit with Dr. Nichols was on April 20. Claimant stated she simply could not go on with her present level of pain. Dr. Nichols stated that he had tried all conservative treatment and referred her again to Dr. Georgis for consideration of surgical intervention. Dr. Nichols continued Claimant on modified work.

The records of Dr. Theodore Georgis and Dr. Howard Tung comprise Claimant's Exhibit 10.[3] On February 12, 1998, Dr. Georgis, a board certified orthopedic surgeon whose practice was limited to spinal disorders, determined that Claimant had L4-5 central disc herniation with collapse and instability, smaller L3-4 disc protrusion, and bilateral lumbar radiculopathy, right worse than left. He stated that he preferred to exhaust all forms of conservative therapy before considering surgery, though he did note that there was possibly a need for decompressing the L4-5 and possibly stabilization and fusion.

Claimant returned to Dr. Georgis on April 30, 1998 for re-evaluation. She complained of ongoing pain and though she was on light duty at work, she stated that she had been required to do more than what was required by her restrictions. Dr. Georgis diagnosed persistent lumbar radiculopathy and L4-5 disc herniation and protrusion L3-4. Dr. Georgis recommended that Claimant undergo physical therapy and if it did not help, he would consider surgical intervention consisting of a lumbar laminectomy and discectomy at L4-5. Dr. Georgis did not feel that a fusion would be necessary. Dr. Georgis continued Claimant on light duty at work but recommended no lifting above five pounds.

Dr. Georgis saw Claimant again on May 26, 1998, noting that Claimant had been attending physical therapy since May 1 with no major improvement. He noted that the physical therapist recommended aquatic physical therapy for 3 to 4 weeks, and Dr. Georgis determined that if there was no improvement, he would discuss surgery with Claimant.

On June 30, 1998, Dr. Tung opined that Claimant was a surgery candidate for an L4-5 diskectomy and decompression, with possibly stabilization and fusion in the form of a posterior interbody fusion. He did not believe the L3-4 level was unstable and thus would not require a fusion.

[3] Dr. Georgis began as Claimant's spinal surgeon but due to an accident and subsequent disability, Dr. Tung took over Claimant's care.

Dr. William H. Davidson examined Claimant for a second opinion consultation of June 17, 1998. His records are located at Claimant's Exhibit 11 and Employer's Exhibit 2. Following his examination, he concluded that Claimant had a herniated nucleus pulposus at L4-5, a condition which arose out of her employment. Dr. Davidson approved of Dr. Georgis' treatment plan of Claimant having a lumbar laminectomy at L3-4 and L4-5. He agreed with Dr. Georgis that a lumbar fusion was not necessary. Dr. Tung's records contain a fax authorizing Claimant to undergo a lumbar laminectomy at L3-4 and L4-5, but stated that a fusion was not authorized.

On July 28, 1998, Dr. Tung's report stated that Claimant should be placed on temporary total disability because he did not believe she could return to work at her current occupation in her present state. Claimant was scheduled for surgery on August 1, 1998. In another evaluation dated May 24, 1999, Dr. Davidson stated that on August 14, 1998, Dr. Tung indicated that Claimant did not have an unstable spine and that only a lumbar laminectomy was necessary; accordingly, on August 19, 1998 Claimant underwent an L4-5 bilateral laminectomy and diskectomy. A large disc herniation at L4-5 was found. Dr. Tung's report on December 9, 1998 states that Claimant had been making excellent progress but had regressed and was complaining of increasing pain. Dr. Tung kept Claimant off work from December 1, 1998 to January 19, 1999.

Dr. Tung's next report is dated April 13, 1999, wherein Claimant expressed continued complaints of intermittent and moderate right foot numbness and leg pain as well as back pain. Dr. Tung felt that Claimant had plateaued at this point; she had an excellent course of physical therapy, and a post-operative MRI showed no canal stenosis or foraminal stenosis. Dr. Tung declared Claimant at maximum medical improvement (MMI) on this date. Dr. Tung opined that Claimant had sustained a partial permanent disability and should have a permanent work limitation precluding heavy work. (EX 5, p. 103). Dr. Tung determined that Claimant had lost approximately half of her pre-injury capacity for bending, stooping, lifting, pushing, pulling and climbing or other activities involving comparable physical effort. In addition, Dr. Tung placed a weight lift restriction of less than 10 pounds on Claimant, and stated she should be allowed to alternate standing and sitting positions every two hours.

On August 11, 1999, Dr. Tung's notes state Claimant complained of residual and chronic complaints of intermittent right leg pain and back pain. On October 7, 1999, Claimant returned with complaints of unchanged pain and stress

incontinence. Dr. Tung referred Claimant to Dr. Shen Ye Wang, neurologist, who saw Claimant on October 4 and performed a neurological examination. Dr. Wang's impression included persistent bilateral L5-S1 radiculopathy, clinically, and L5-S1 motor radiculopathy on the left side.

On October 21, 1999, Dr. Tung continued Claimant's work restrictions of no prolonged walking or standing, the ability to alternate between sitting and standing every two hours, and stated that the ten pound weight lift restriction was essential. He released Claimant to work limited duty beginning October 26, 1999.

Claimant returned to Dr. Tung for a follow-up visit on November 30, 1999, where according to the report, Claimant complained of some difficulties with her back and lower extremities while working, especially when she was asked to stand for too long at the front desk. Dr. Tung noted that he reviewed her restrictions with her and reminded her of the importance of adhering to them. On December 28, 1999, Claimant returned to Dr. Tung where she complained of worsening pain in her back which occasionally shot into her right leg, some numbness in the left leg and lumbosacral spasms. Dr. Tung noted that the standing requirements of the desk clerk job appeared to be too much for Claimant and accordingly he took her off work from December 28, 1999 to February 8, 2000, and began a course of physical therapy. He subsequently kept her off work from February 8 to March 21.

On March 7, 2000, Claimant returned to Dr. Davidson for a "medical-legal evaluation." This report is found at Employer's Exhibit 2, p. 51. Dr. Davidson opined that based on the records he reviewed and Claimant's history, he agreed with Claimant's other doctors that she had an injury as a result of repetitive lifting occurring during the course of her employment. He felt she had undergone appropriate medical treatment including a lumbar laminectomy and diskectomy, and he determined she had reached MMI at that point.

On March 21, 2000, Claimant returned to Dr. Tung whose notes indicate her complaints of pain were unchanged. He noted that she attempted to return to work but could not tolerate doing so because the restrictions in place "could not be adhered to." Claimant did report some relief from participating in water therapy. Dr. Tung noted that he discussed options with Claimant to deal with her residual pain. The only surgical option was a lumbar fusion at the L4-5 level. He noted that Claimant opted to continue with the medical supportive treatment she had been doing.

Dr. Tung's records contain a letter dated November 1, 2000 to Employer Carrier regarding a desk clerk job description. He stated that after reviewing the description, he felt that Claimant could fulfill the requirements because Employer was willing to modify the sitting, standing and bending requirements to meet his restrictions. He felt that as long as Claimant could sit or stand as needed, she should not have a problem performing the job.

Claimant returned for a visit on November 21 where Dr. Tung noted that she presented with unchanged complaints of back pain which had been relatively stable. He advised her to continue with an exercise program. Notes dated February 13, 2001 state that Claimant had been working at her previous job duties and reported occasional flare-ups from prolonged sitting and standing. Dr. Tung noted that he had reviewed some alternative job descriptions, including appointment clerk, customer service clerk, inside sales representative, and unarmed security guard, and he believed Claimant would be physically capable of performing these positions. In addition, he noted that if Claimant were to have worsening or intractable symptoms, she could be a candidate for a L4-5 lumbar fusion.

Claimant visited Dr. Tung again on March 28, 2001 complaining of a recent worsening of her condition due to a fall she sustained at work on March 23 while descending steps, resulting in her leg giving out. Claimant's Exhibit 9 contains the report from Camp Pendleton Emergency Care. It states that Claimant was brought by ambulance and that her chief complaint was right foot and hip injury. She reported severe pain since that time and also reported cervical pain. She was unable to work since the fall. Dr. Tung opined that Claimant should proceed with conservative treatment and kept her off work until May 1. He ordered MRIs of the lumbar and cervical spine which he reviewed on May 1, 2001 and showed recurrent herniated disc and degenerative disc disease. He believed she was a candidate for fusion at the L4-5 level because she had symptoms prior to the fall which worsened after the fall with only minimal improvement. Dr. Tung stated that he discussed the risks and benefits of the surgery with Claimant and that she was comfortable and wanted to proceed. Dr. Tung stated he would keep Claimant off work for four to six weeks until the surgery could be scheduled.

Claimant's Exhibit 8 consists of the consultation performed by Dr. Mark H. Mikulics, a board certified orthopedic surgeon who specializes in hand surgery. Dr. Mikulics saw Claimant on March 28 for injuries she sustained when she fell on March 23. During the consultation, Claimant complained of low back and tail bone

pain radiating to her buttocks with spasms on the right side, bilateral numbness and tingling. She stated she had to shake her hands in the morning for them to awaken.

Dr. Mikulics performed a physical examination and diagnosed Claimant with bilateral carpal tunnel syndrome. He concluded that no one specific incident caused Claimant's disability, rather, there had been a cumulative effect while engaged in an occupation which involved a great deal of repetitive activity. He determined that Claimant had signs and symptoms consistent with carpal tunnel syndrome and had not reached a stable plateau, but additional diagnostic studies were warranted.

Claimant relocated to North Dakota and never followed up with either Drs. Tung or Mikulics. The next medical treatment Claimant received was from Dr. Charles B. Stillerman, a neurosurgeon in Minot, ND. Dr. Stillerman's records are located at Claimant's Exhibit 7. Dr. Stillerman examined Claimant on August 20, 2001 and noted that the physical and neurological exam was unremarkable. He stated that he thought she may be a reasonable candidate for a re-exploration, fusion and stabilization procedure at the L4-5 level, and this should be done at a comprehensive spine institute such as the University of Minnesota. He also stated that Claimant should establish ongoing care with a family physician.

Claimant's Exhibit 4 contains reports from Dr. Kon-Hweii Lee, a neurologist in Minot who first examined Claimant on September 13, 2001 at the request of Dr. Stillerman. Dr. Lee conducted an EMG and a nerve conduction study as well as a physical examination including pinprick test. Dr. Lee concluded that the EMG and nerve conduction studies were grossly normal, showing no evidence of carpal tunnel syndrome or other entrapment neuropathy. He determined that Claimant may have had overuse strain injury, but because of the diffuse pain Claimant complained of, Dr. Lee suspected she may have had chronic fibromyalgia. Dr. Lee later answered questions regarding Claimant's condition posed to him via fax by claims adjuster Tracie True. He stated that Claimant was at MMI with regard to her hands, wrists and neck injury of March 20, 2001. The permanent restrictions he attached to the injury were no strenuous activities, repetitive action or heavy lifting. The future medical treatment Dr. Lee anticipated for this injury included anti-inflammatories, heating pad, resting if needed, and stretching exercises.

Claimant's Exhibit 3 is comprised of medical reports from Dr. Howard E. Reeve, a physician with the Department of Family Medicine and Occupational Medicine at Trinity Medical Group in Minot. In his progress note dated January 4,

2002, Dr. Reeve stated that Claimant complained of pain in her lower back which went around her right hip area inside the right thigh and down the leg. Dr. Reeve determined that Claimant would benefit from attending a chronic pain program because Claimant did not want to undergo surgery. Dr. Reeve also recommended referring Claimant to Dr. Morris, a urologist, because Claimant was beginning to have incontinence problems which Dr. Reeve opined was likely due to nerve damage from her back injury and previous surgery. Finally, Dr. Reeve recommended that Claimant attend acupuncture since it had helped her in the past, as well as a neuromuscular therapist.

Dr. Reeve's progress note on January 11, 2002 indicates that Claimant had suffered a fall at home. She reportedly landed on her left side, injuring her left shoulder, elbow, left hip area, and reinjured her back. She was seen in the emergency room, the records for which are located at Claimant's Exhibit 5. She did not break any bones, and a CT scan was performed with a normal result. Dr. Reeve noted contusions on her left hip and shoulder and noted that she strained her back when she fell.

In a letter to the Carrier dated March 26, 2002, Dr. Reeve answered some questions that had been posed to him. He stated that he doubted Claimant could return to her pre-injury work status because she was having severe back pain and muscle spasms, so he did not think she could be employed consistently even if the job was sedentary. He noted that her back had very little range of motion and was having palpable muscle spasms. He stated that Claimant's restrictions should be considered permanent unless she had some sort of miraculous recovery from a surgical procedure or therapeutic modality. He opined that she had reached MMI as of that date and would need continuing medical treatment.

Employer/Carrier contacted Dr. Gregory Peterson to conduct an independent medical evaluation of Claimant. His records comprise Employer's Exhibit 1. Dr. Peterson examined Claimant on April 25, 2002 and reviewed her medical records. He concluded that Claimant had complaints of pain and disability markedly out of proportion to objective findings. He found it likely that she had mechanical type low back pain related to her degenerative disc disease, but saw no indication that she had active radiculopathy, spinal stenosis or spinal instability. He also noted that it did not appear that she ever had carpal tunnel syndrome.

Dr. Peterson reviewed the desk clerk job description and opined that Claimant was physically capable of performing all of the duties it entailed. He recommended no additional medical treatment for Claimant's upper extremity and

upper body pain complaints, but he did believe that a pain management program would benefit Claimant by helping her establish independent pain coping strategies. Dr. Peterson determined that Claimant was at MMI and that her restrictions should include no lifting more than 20 pounds occasionally and 10 pounds frequently. He also recommended against frequent or prolonged bending, squatting, or kneeling, and felt that Claimant should be allowed to change position at least once every two hours.

Dr. Reeve reviewed Dr. Peterson's IME report, and in a letter to Tracie True dated July 8, 2002, he stated that he "pretty much" agreed with Dr. Peterson's findings. He reiterated the need for a pain management program. His next progress note is dated October 10, 2002, where he stated Claimant visited for an update. He noted that Claimant complained of increasing weakness, that her right leg had been buckling out from under her at times, and she had pain radiating down her right leg along with some numbness and twitching sensations into the upper right thigh. Dr. Reeve noted that Carrier had never contacted Claimant regarding the recommended pain management program. He requested another MRI.

An October 23, 2002 letter to Dr. Reeve stating receipt of MRI request was sent by Tracie True. She authorized referring Claimant to a pain program. She also attached job descriptions for desk clerk and general clerk and asked Dr. Reeve to review the requirements. Dr. Reeve determined that Claimant was not able to perform the duties of desk clerk or general clerk due to her neurological symptoms and her legs giving out. However, in a letter to Ms. True dated January 24, 2003, Dr. Reeve stated that he reviewed job descriptions provided by Kent Schafer. He felt that Claimant was unable to do anything more than a sedentary type job, and cashier and daycare worker positions identified by Mr. Schafer appeared to be sedentary. Dr. Reeve did state that he doubted Claimant would be able to perform these jobs because of her educational deficits.

Dr. Reeve's next progress note is dated February 25, 2003, where he noted Claimant had been through the pain management program and he thought it had helped as far as her chronic pain problems, though he noted that she still had complaints of pain in her lower back with radiation down her right leg. On March 2, 2003, Dr. Reeve stated that Claimant's most recent x-ray showed degenerative disc disease with narrowing of the disc spaces "pretty much throughout." In a letter to Ms. True dated July 22, 2003, Dr. Reeve stated that the most recent MRI did not show anything that could be fixed surgically or any significant problem.

Around this time, Claimant began seeing Dr. Maya Dillas as her primary care physician for other health problems. Dr. Dillas' records are found at Claimant's Exhibit 6. Claimant's first visit was April 29, 2003 where she presented with complaints of chronic cough, urinary incontinence and back pain. Claimant was diagnosed with acute bronchitis, hypertension, and back pain. The note dated June 30, 2003 states that Claimant saw Dr. Morris who diagnosed her with stress urinary incontinence and decreased bladder sensation, discussed treatment with her and referred her to an OB/GYN. The remainder of Dr. Dillas' notes deal primarily with Claimant's asthma, chronic obstructive pulmonary disease, hypertension, hyperglycemia, and hyperlipidemia.

Dr. Dillas referred Claimant to Dr. Lee who saw her again on May 24, 2004. His report is found at Claimant's Exhibit 4. Dr. Lee conducted an EMG and nerve conduction study of the upper extremities which showed very mild carpal tunnel syndrome on the right side, borderline carpal tunnel syndrome on the left side, and mild entrapment neuropathy of ulnar nerve at the left elbow. The MRI of the cervical spine, taken May 4, 2004, showed small central posterior disc protrusion at C3-4 resulting in mild canal stenosis.

Claimant's Exhibit 2 consists of the records of Tri-Life Center, beginning with Claimant's initial evaluation on January 21-22, 2003. Claimant was deemed appropriate for admission to the program based on the fact that she met the AMA diagnostic criteria for chronic pain syndrome and her depression as evidenced by her score on the Beck depression Inventory which the treatment team felt was a direct result of her work related injury and resulting chronic pain.

Claimant began the three-week program on January 27, 2003. The notes from the first week mention stress due to a situation regarding Claimant's boyfriend. Claimant's first week physical therapy progress note stated she participated in aquatic therapy, tai chi, stretching and strengthening, education, and group therapy.

Claimant's records pertaining to her second week in the program state she was more anxious and nervous, but was doing fairly well in the program and had shown a decrease in chronic pain behaviors. The records relating to the third and final week of the program indicate that she continued to have a fair amount of psychosocial distress. The clinical staff felt that she needed a couple more weeks in a refresher course because she was fairly slow and had a hard time identifying things that worked for her in the program.

In a letter to Ms. True dated February 18, 2003, Ms. Sjol, the program director, stated that though Claimant had completed the three-week program, due to her learning difficulties it was determined by the treatment team that she should repeat the program at no charge to the insurance company. She further stated that due to her physical and academic disabilities, the team did not believe that Claimant was capable of any meaningful work. The team recommended that after completion of the second program, Claimant attend the adult learning center as well as attend psychotherapy. The records regarding Claimant's second stay at the program indicate that she continued to report pain symptoms, as do the notes from her recheck appointments which were scheduled every two months. The notes indicate that Claimant was using pain management techniques at home.

Dr. Peterson's records show he conducted another IME on June 7, 2004. He noted that since the last IME on April 25, 2002, Claimant had completed the Tri-Life program which Claimant stated was one of the best things that had ever happened to her, but when Dr. Peterson asked Claimant if she physically felt any better, she replied that she did not. He noted that on October 22, 2003, Claimant had an aortic valve replacement. Claimant stated that problems related to her spine, leg, arms and bladder continued. He noted her current medications.[4] Dr. Peterson concluded that in terms of Claimant's chronic pain problem, there had been no overall significant change, though she did demonstrate somewhat less pain behaviors than he noted previously. He stated that if Claimant did have carpal tunnel syndrome now, it would be unrelated to her work injury. Overall, Dr. Peterson found no new information since the last IME that would significantly change his impression as noted in that report.

Dr. Peterson stated that he felt that Claimant's chronic pain syndrome and associated psychological factors are minimally related to her March 23, 2001 injury. He opined that she was physically capable of performing work in the "light" restriction category, including the job descriptions he reviewed for desk clerk and general clerk positions. He stated that he felt Claimant was employable continuously since the time of his last IME with the exception of the time she was restricted from work due to her cardiac condition. Finally, he believed that the treatment provided by Tri-Life Center was reasonable and appropriate, but he felt

[4] Claimant's list of medications as of 6/4/04 includes: Vicodin, Neurontin, Ditropan XL, Bisacodyl, C-Depo-Testosterone cream, Propoxyphene-N, Depakote, Wellbutrin, Fexofenadine, multivitamin, nebulizer with Albuterol and Ipratropium, Flonase inhaler, Seravent inhaler, Folvent and Combivent, Prilosec, Lexapro, Temazepam, Enalapril, Synthroid, Atenolol, Aspirin, Lasix, Potassium, Metformin, Clonidine, Gemfibrozil, Lipitor, Simethicone, and Singular.

that it was provided for psychological reasons unrelated to Claimant's occupational injury.

Non-Medical Evidence

The records of Joyce Gill, the vocational rehabilitation specialist whose testing was previously discussed, are located at Employer's Exhibit 13. Ms. Gill received Claimant's file from the Department of Labor on June 8, 1999, and met with Claimant on June 22 where she took medical, education and employment histories. On June 23 Ms. Gill noted that she spoke with Employer who thought they could accommodate Claimant but found out the position they had for her had been filled.

On July 7, 1999 Ms. Gill administered vocational testing to Claimant. On August 3, Ms. Gill attempted to identify industrial training programs appropriate for Claimant in the San Diego area. Ms. Gill set up a meeting for Claimant to visit an electronic assembly program, and Claimant went to the appointment but felt she was not able to handle any type of training at that time due to her medical condition.

Claimant called Ms. Gill on August 12, 1999 and stated she had an appointment with Dr. Tung who had received a job description from Employer. This description was for the desk clerk position, and on August 30, Claimant told Ms. Gill she did not want to return to Employer in that position. Ms. Gill's notes state that she told Claimant that if Dr. Tung approved the position, Claimant had little choice but to return. On September 27, Ms. Gill indicated that Carrier had received approval from Dr. Tung for the desk clerk position. Claimant accepted the position on September 27 to begin work on October 4, 1999. Ms. Gill spoke with Julie Morris at Camp Pendleton who stated that Claimant continued to work and everything appeared to be going well; she anticipated that Claimant would be able to continue to work without difficulty.

Employer's Exhibit 12 contains the records of Ms. Amy Wise, another vocational rehabilitation counselor. Ms. Wise's records indicate that Claimant's case was referred to her on August 28, 2000 for the purpose of conducting a labor market survey. Ms. Wise reviewed all medical records provided by Employer/Carrier and Claimant's attorney and met with Claimant on November 2, 2000 to conduct an evaluation and administer vocational testing. Ms. Wise administered a Career Ability Placement Survey aptitude test. Claimant scored either below average or slightly below average on every aspect of the test,

including mechanical and verbal reasoning, spatial relations, numerical ability, language usage, word knowledge, perceptual speed and accuracy, and manual speed and dexterity.

Based on Claimant's vocational profile, physical demand levels, working conditions, general education development levels, aptitude levels and work history, Ms. Wise identified the following positions as appropriate: appointment setter clerk, parking lot cashier, car wash cashier, ticket seller, unarmed security guard, and other appropriate positions.

Ms. Wise ultimately found five positions for Claimant which were subsequently approved by Dr. Tung on February 13, 2001. These positions included customer service clerk, inside sales clerk, appointment setter clerk, unarmed security gate guard, and appointment setter clerk/inside sales clerk. The pay for the jobs ranged from $6.25 to $9.00 per hour. Ms. Wise noted that Claimant did not apply for any of these jobs, as she had returned to work with Employer in the front desk clerk position. Ms. Wise closed Claimant's labor market survey file on March 2, 2001.

Employer's Exhibit 14 contains the records of Mr. Kent Schafer, a vocational rehabilitation counselor located in Bothell, Washington. Mr. Schafer was contacted by Tracie True on October 23, 2002 to conduct a transferable skills analysis and a full scale labor market survey with regard to Claimant. Ms. True asked Mr. Schafer to locate at least six current openings in at least three different job categories that paid equal to or above $194.28 per week, which was Claimant's wage at the time of her injury.

By letter dated November 20, 2002, Mr. Schafer contacted Claimant with a list of positions that Mr. Schafer determined Claimant would be physically capable and qualified to perform. These positions included day care attendant at a child care center, and child development program assistant, lodging clerk, and cashier, all at Minot Air Force Base. All the jobs paid $5.15 per hour. Mr. Schafer later identified four additional positions: gas station cashier, convenience store cashier, hotel front desk clerk, and sewing machine operator, all located in Minot. These jobs paid $6.00 per hour. In a letter to Ms. True dated December 10, 2002, Mr. Schafer outlined the above positions he had found for Claimant. Based on his review of Claimant's medical file, Mr. Schafer opined that Claimant retained access to a wide range of entry-level, unskilled forms of employment. Mr. Schafer stated that the positions he located complied with the restrictions indicated by Dr. Peterson in his IME, namely, lifting no more than 20 pounds occasionally and 10

pounds frequently, plus being allowed to change position at least once every two hours and no prolonged or frequent bending, squatting, or kneeling. Mr. Schafer stated he had tried to contact Claimant through her attorney without avail.

Dr. Peterson approved all but two of the jobs on December 16, 2002. He stated that the day care attendant and child development program assistant positions, which involved crouching, stooping, bending and low sitting would be difficult for Claimant due to her back pain complaints. Mr. Schafer wrote to Ms. True on January 17, 2003, stating he had made contact with the potential employers regarding Claimant's follow-up. He stated that Claimant had not contacted any of the employers regarding any of the positions.

Claimant's Exhibit 1 contains OWCP vocational rehabilitation reports compiled by Linda Magee Jones, rehabilitation specialist, and the results of tests that were administered to Claimant at Minot Adult Learning Center on March 10, 2003. The test results indicate that Claimant's aptitude level was third grade and lower for reading, math computation, applied math, language and spelling. After reviewing the Adult School test scores, Ms. Jones stated that it was clear that Claimant was not capable of performing any of the positions identified because of her below average demonstrated assessment of cognitive processing and general learning ability. Ms. Jones determined that Claimant needed a position where she could learn new information at her own pace and in which the job offered familiar work, therefore vocational rehabilitation was necessary.

Claimant's file was again referred to Ms. Amy Wise on June 17, 2003 and March 5, 2004 to conduct a retroactive labor market survey back to February 2003 and an updated labor market survey to determine Claimant's then-existing employability and wage-earning capacity in the North Dakota geographical area. Ms. Wise reviewed Claimant's OWCP vocational rehabilitation report, Claimant's permanent and stationary report by Dr. Peterson, and Kent Schafer's labor market survey. Her report is found at Employer's Exhibit 12, p. 181.

Ms. Wise spoke to Claimant on April 7, 2004, when Claimant told her that she did not feel she was able to work as she is taking pain medication and has constant back pain. Claimant also stated she had open heart surgery five months prior and was recovering. On May 17, Ms. Wise was informed by "employer at Camp Pendleton" that there were no appropriate positions for Claimant at that time. Ms. Wise conducted labor market research in the North Dakota area on May 10, 2004, May 19, 2004, and May 21, 2004.

After reviewing Claimant's various test scores, including those from Minot Adult School, Ms. Wise concluded that Claimant required occupations that would consider an applicant with very limited spelling ability and limited to no numerical ability. Ms. Wise located four positions that she deemed suitable considering Claimant's limited spelling, reading, and math aptitude levels: tele-fundraising clerk, reservation clerk, appointment setter clerk, and PBX operator. All of these positions were found to be physically appropriate and within Claimant's physical restrictions as noted by Dr. Peterson. The jobs paid between $8.00 and $10.00 per hour and were located in the north San Diego area where Camp Pendleton is located.

Employer's Exhibit 16 and Claimant's Exhibit 16 contain copies of dates and amounts of compensation paid to Claimant, notices of controversion, and the Notice of Final Payment or Suspension of Compensation Payments. This statement shows that Claimant was paid a total of $31,121.14 based on an average weekly wage of $194.78. The last payment was made on March 28, 2001. Regarding the March 23, 2001 injury, the records show that Claimant was paid a total of $18,225.86 for the period of March 28, 2001 through January 11, 2003.

Employer's Exhibit 17 consists of a letter from Ida Hairgrove, MCCS human resources division to Employer/Carrier. The letter is dated May 3, 2002 and states that a permanent position accommodating Claimant's permanent restrictions would have been available had Claimant not voluntarily resigned.

Both Employer's Exhibit 18 and Claimant's Exhibit 18 are comprised of Claimant's wage earnings for the period of December 21, 1996 through August 30, 1997. It reflects that Claimant's rate of pay was $6.16 per hour and that she worked a total of 989.5 hours, resulting in total payment of $5980.19. Additionally, CX 18, p. 296 shows Claimant's earnings for the period of April 8, 2000 through March 24, 2000 as $5306.68, at a rate of $7.54 per hour. There is also a pay stub from Claimant's job at Target, showing a rate of $5.30 per hour. Claimant had worked 200.5 hours and her gross earnings were $1421.29.

Employer's Exhibit 19 and Claimant's Exhibit 17 are copies of the light duty housekeeping job duties for the position offered by Employer on February 25, 1998. The duties listed are dusting furniture, stamping and folding linens, replacing amenities, cleaning coffee makers, replacing towels, soap, toilet paper, etc. It contains Claimant's signature evidencing acceptance of the position effective March 6, 1998. Employer's Exhibit 20 is a form signed by Julie Morris,

dated July 27, 1999, stating that light or modified duty existed for Claimant at that time.

Employer's Exhibit 21 is a letter from Kevin P. Marr, Billeting Manager, to Insurance Carrier dated March 17, 2000. The letter states that Claimant's restrictions were accommodated while she worked at the front desk. It states that Claimant was permitted at her own discretion to sit, stand, move around and take breaks as needed. Employer's Exhibits 22 & 23 are correspondence with Dr. Tung wherein he approved the desk clerk position provided there was no bending or twisting at the waist. Employer's Exhibit 24 is dated May 28, 2001 and is a "normal day" for Claimant in the desk clerk position, but it appears to only cover part of the day and there is no indication who compiled the list.

Findings of Fact and Conclusions of Law

The following findings of fact and conclusions of law are based upon my observation of the appearance and demeanor of the witnesses who testified at the hearing and upon an analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. In evaluating the evidence and reaching a decision in this case, I have been guided by the principles enunciated in *Director, OWCP v. Maher Terminals, Inc*., 114 S. Ct. 2251 (1994) that the burden of persuasion is with the proponent of the rule. Additionally, as trier of fact, I may accept or reject all or any part of the evidence, including that of medical witnesses, and rely on my own judgment to resolve factual disputes or conflicts in the evidence. *Todd Shipyards v. Donovan*, 300 F.2d 741 (5th Cir. 1962). The Supreme Court has held that the "true doubt" rule, which resolves conflicts in favor of the claimant when the evidence is balanced, violates § 556(d) of the Administrative Procedures Act. *Director, OWCP v. Greenwich Collieries*, 114 S.Ct. 2251, 28 BRBS 43 (1994).

Causation

Section 20 (a) of the Act provides claimant with a presumption that her disabling condition is causally related to her employment if she shows that she suffered a harm and that employment conditions existed which could have caused, aggravated or accelerated the condition. *Merrill v. Todd Pacific Shipyards Corp.*, 25 BRBS 140 (1991); *Stevens v. Tacoma Boat Bldg. Co*., 23 BRBS 191 (1990). The Section 20 (a) presumption operates to link the harm with the injured employee's employment. *Darnell v. Bell Helicopter Int'l, Inc.,* 16 BRBS 98 (1984).

Once the claimant has invoked the presumption the burden shifts to the employer to rebut the presumption with substantial countervailing evidence. *Ortco Contractors, Inc. v. Charpentier*, 332 F.3d 283 (5th Cir., 2003), *James v. Pate Stevedoring Co.*, 22 BRBS 271 (1989). If the Section 20 (a) presumption is rebutted, the administrative law judge must weigh all the evidence and render a decision supported by substantial evidence. *Del Vecchio v. Bowers*, 296 U.S. 280 (1935).

August 31, 1997 and March 23, 2001

In this instance, Claimant and Employer stipulated in Joint Exhibit 1 that an injury/accident occurred on August 31, 1997, and March 23, 2001 during the course and scope of Claimant's employment. I find that a harm and the existence of working conditions which could have caused that harm have been shown to exist, and I accept the parties' stipulation. Claimant clearly injured her back while performing the duties of housekeeper and front desk clerk. The extent, duration and disabling effects of those injuries, however, are in issue.

March 21, 2001

In issue is the injury Claimant alleges she suffered to her arms and hands, resulting in Carpal Tunnel Syndrome, on March 20, 2001. Whether this injury occurred during the course and scope of employment is disputed by the parties. Arguably, even if Claimant invoked the Section 20 (a) presumption, the presumption is clearly rebutted by substantial evidence, consisting of the reports and testimony of Dr. Peterson, and when weighed as a whole does not support Claimant's contentions.

The initial evaluation of Claimant's hands was performed by Dr. Mikulics on March 28, 2001, who subsequently diagnosed bilateral Carpal Tunnel Syndrome based on classic signs and symptoms of such, though no specific incident was noted as causing the alleged syndrome. However, Dr. Mikulics did not review any diagnostic tests in making his diagnosis, and Dr. Peterson testified that electromyocardiogram (EMG) nerve conduction studies are the best diagnostic tool because physical examinations are subjective and rely on the patient's report, thus making diagnosis more risky. Also, when EMG nerve conduction studies were eventually performed by Dr. Lee on September 13, 2001, he found them to be grossly normal.

Granted, nearly three years later, the tests were repeated with a result of very mild Carpal Tunnel Syndrome on the right side and borderline on the left; however, Dr. Peterson testified that the different results several years apart could be explained by a variety of factors, including diabetes which Claimant had symptoms of. Dr. Peterson stated that it would be difficult, if not impossible, to link these mild changes to Claimant's earlier alleged industrial injury because the tests conducted immediately following that alleged injury were normal. Consequently, when all the evidence is weighed, I find that the presumption has been rebutted with substantial evidence, and when weighed as a whole, the evidence does not support a finding that if in fact Claimant now suffers from Carpal Tunnel Syndrome that it is related to her earlier employment.

Nature and Extent

Having established that injuries occurred on August 31, 1997, and March 23, 2001, the burden now rests with Claimant to prove the nature and extent of her disability. *Trask v. Lockheed Shipbuilding Construction Co.,* 17 BRBS 56, 59 (1985). A claimant's disability is permanent in nature if she has any residual disability after reaching maximum medical improvement (MMI). *Id*. at 60. Any disability before reaching MMI would thus be temporary in nature.

The date of maximum medical improvement is defined as the date on which the employee has received the maximum benefit of medical treatment such that her condition will not improve. The date on which a claimant's condition has become permanent is primarily a medical determination. *Mason v. Bender Welding & Mach. Co.,* 16 BRBS 307, 309 (1984). The date of maximum medical improvement is a question of fact based upon the medical evidence of record regardless of economic or vocational consideration. *Louisiana Insurance Guaranty Assoc. v. Abbott*, 40 F.3d 122, 27 BRBS 192 (CRT) (5th Cir. 1994); *Ballesteros v. Willamette Western Corp.,* 20 BRBS 184, 186 (1988); *Williams v. General Dynamics Corp.,* 10 BRBS 915 (1979).

Regarding Claimant's August 31, 1997 injury, the parties agree she reached MMI on April 13, 1999. However, the parties are in disagreement regarding the date of maximum medical improvement of Claimant's March 23, 2001 injury. Employer contends that Claimant reached MMI on March 26, 2002, whereas Claimant asserts that MMI was not reached until July 22, 2003. Dr. Reeve stated in a letter to Tracie True on March 26, 2002: "I think Ms. Enno has probably reached maximum medical improvement now;" and, in a similar letter to Ms. True

dated July 22, 2003, Dr. Reeve stated: "You wondered whether she had reached MMI for her work injury of 03/23/01. I think she has."

As Claimant's then treating physician, I accept Dr. Reeve's initial date of MMI, March 26, 2002, as it regards Claimant's injury of March 23, 2001. It is apparent from the record that Claimant's complaints did not change over the course of the year. The treatment provided by Dr. Reeve consisted of continuing Claimant's same course of medication and requesting another MRI, but there is no evidence or testimony that there was any improvement or change in Claimant's physical condition. In addition, Dr. Peterson stated that Claimant had reached MMI as of his first evaluation dated April 25, 2002, and I find that supports Dr. Reeve's opinion. Therefore, based on the totality of the medical evidence, I agree with Employer that Claimant's condition did not benefit from medical treatment or achieve any significant improvement after March 26, 2002. Any compensation awarded after this date will be permanent in nature.

The question of extent of disability is an economic as well as medical concept. *Quick v. Martin*, 397 F.2d 644 (D.C. Cir. 1968); *Eastern S.S. Lines v. Monahan*, 110 F.2d 840 (1st Cir. 1940). A claimant who shows she is unable to return to her former employment establishes a prima facie case of total disability. The burden then shifts to the employer to show the existence of suitable alternative employment. *P&M Crane v. Hayes, 930 F.2d 424, 430* (5th Cir. 1991); *N.O. (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1038, 14 BRBS 1566 (5th Cir. 1981). Furthermore, a claimant who establishes an inability to return to her usual employment is entitled to an award of total disability compensation until the date on which the employer demonstrates the availability of suitable alternative employment. *Rinaldi v. General Dynamics Corp*., 25 BRBS 128 (1991). If the employer demonstrates the availability of realistic job opportunities, the employee's disability is partial, not total. *Southern v. Farmer's Export Co*., 17 BRBS 64 (1985). Issues relating to nature and extent do not benefit from the Section 20 (a) presumption. The burden is upon Claimant to demonstrate continuing disability (whether temporary or permanent) as a result of her accident.

In order to establish suitable alternative employment, an employer must show Claimant is capable of working, even if it's within certain medical restrictions, and there is work within those restrictions available to him. *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1042-1043, 14 BRBS 156, 164-165 (5th Cir. 1981), *rev'g* 5 BRBS 418 (1977). An employer can meet its burden of suitable alternative employment by offering the claimant a job in its facility, *Spencer v. Baker Agricultural Co.*, 16 BRBS 205 (1984), including a light-

duty job, so long as it does not constitute sheltered employment. *Darden v. Newport News Shipbuilding & Dry Dock Co.*, 18 BRBS 224 (1986); *Harrod v. Newport News Shipbuilding & Dry Dock Co.*, 12 BRBS 10, 12-13 (1980). If the claimant relocates for personal reasons, the employer meets its burden if it shows that jobs are available within the geographical area in which the claimant resided at the time of the injury. *Elliot v. C&P Telephone Co.*, 16 BRBS 89, 92 (1984).

Claimant's August 31, 1997 Injury

The extensive medical records regarding Claimant's August 1997 injury establish that she was temporary totally disabled until she returned to light-duty work with Employer. However, even while working, her treating physicians removed her from work for various periods of time. Because Claimant was not able to earn wages during these intervals, her disability during periods she was removed from work by a physician would revert to total.

The parties agree that Claimant was temporary total disabled beginning September 5, 1997, continuing until she returned to work for Employer. The records establish that Claimant accepted the light duty housekeeping position on March 6, 1998 and returned to work on March 9, 1998. (EX 19, p. 321). Claimant worked at the light duty housekeeping job for several months, but there were intermittent brief periods that she was temporarily removed from work.

Claimant was removed from work by Dr. Wardrip from March 24, 1998 until April 3, 1998, due to a severe spinal headache she suffered as a side effect from epidural steroid injection treatment. (CX 12). Dr. Georgis removed Claimant from work from May 8, 1998 through May 26, 1998 (CX 10, p.207). Dr. Tung declared Claimant to be temporary totally disabled on July 28, 1998. Dr. Tung did not believe that Claimant could return to work at her usual occupation at her then-existing state. (CX 10, p. 199; EX 5, p.111). Claimant subsequently had back surgery performed, and Dr. Tung declared her to have reached MMI regarding the August 1997 injury on April 13, 1999. (EX 5, p.103).

Subsequent suitable alternative employment was not established by Employer until Dr. Tung approved the position of front desk clerk on August 31, 1999. (EX 22, p.325). Although he approved this position, he proceeded to keep Claimant on total disability status until October 21, 1999 (CX 10, p. 188; EX 5, p. 101) and extended Claimant's total disability status until October 24, 1999 (EX 5, p.100). From the records it appears that Claimant began work in that position on October 26, 1999 (EX 16, p. 317A).

Dr. Tung again removed Claimant from work on December 28, 1999 through February 8, 2000 (EX 5, p. 95; CX 10, p. 181) and further extended Claimant's absence through March 21, 2000 (CX 10, p. 179; EX 5, p. 92). Dr. Tung reiterated his opinion that Claimant was permanent and stationary on March 21, 2000. (CX 10, p.176; EX 5, p. 95). Claimant's wage earning records indicate that she returned to work as a front desk clerk in the beginning of April, 2000. (CX 18, p. 296). On May 23, 2000, Dr. Tung imposed new restrictions on Claimant, including a ten-pound lifting restriction, and noted that Claimant was capable of working eight hours per day with the requirement of 10-15 minute breaks every one to two hours. (CX 10, p. 163). On November 1, 2000, Dr. Tung approved the front desk clerk position because it appeared to comply with his restrictions. (EX 5, p. 86). The records do not indicate that Claimant was removed from work again until after her subsequent accident; and because this position adhered to Dr. Tung's restrictions, I find that the desk clerk position constituted suitable alternative employment.

A claimant is obligated to take employment within her physical restriction and the employer is responsible for the difference between a claimant's new weekly wage and her former weekly wage. When suitable alternative employment is shown, the wages which the new position would have paid at the time of the claimant's injury are compared with the claimant's pre-injury wage to determine if she has sustained a loss of wage-earning capacity. *Richardson v. General Dynamics Corp.*, 23 BRBS 327, 330 (1990). Total disability becomes partial disability on the earliest date that the employer establishes suitable alternative employment. *Palomobo v. Director, OWCP*, 937 F.2d 70, 25 BRBS 1 (CRT) (2d Cir. 1991). The ultimate objective in determining wage earning capacity is to determine the wage that would have been paid in the open market under normal employment conditions to the claimant as injured. *Devillier v. National Steel & Shipbuilding*, 10 BRBS 649, 660 (1979). However, the open market is irrelevant where the employer provides a non-sheltered position that is within the claimant's physical restrictions. *Walker v. Sun Shipbuilding & Dry Dock Co.*, 12 BRBS 691, 694 (1980).

Claimant's payroll records pertaining to the desk clerk job indicate that she worked an average of 15 hours per week (30 hours per pay period) at an hourly rate of $7.54, however, Monique Ramirez testified that the position was available 40 hours per week at the time it was offered to Claimant, as well as at the time of hearing. (Tr. p. 168). In addition, Dr. Tung stated that Claimant was capable of working eight hours per day if restrictions were adhered to. (CX 10, p.163).

Claimant testified that she was able to take breaks, and correspondence from Employer stated that Claimant's restrictions were adhered to. Consequently, because there is ample evidence that the 40 hour per week job was available to Claimant, within her restrictions and approved by Dr. Tung, I find that Employer has established Claimant's wage-earning capacity as of November 1, 2000 was $301.16 per week, with no resultant loss of pre-accident wage-earning capacity.

Claimant's March 23, 2001 Injury

Claimant was temporary totally disabled immediately following her work-related injury on March 23, 2001 as evidenced by her treating physician, Dr. Tung, keeping her off work. Dr. Tung removed her from work on March 28, 2001 until May 1, 2001. When Claimant returned for an appointment May 1, Dr. Tung stated he would keep her off work for 4-6 weeks until surgery was scheduled. This was never accomplished because Claimant relocated to North Dakota of her own volition.

Following Claimant's return to North Dakota, and in the absence of any earlier evidence, I find that Claimant was totally disabled until April 25, 2002, the date Dr. Peterson stated she could be employed. Dr. Peterson testified at the hearing that he believed Claimant was continuously employable from the date of his first evaluation, April 25, 2002. In contrast, Dr. Reeve stated on March 23, 2002 that he doubted she could be employed consistently, even in a sedentary position. However, Dr. Reeve stated one month later that he "pretty much agreed" with Dr. Peterson's findings, yet Dr. Reeve did not specifically indicate that he thought Claimant could work until January 24, 2003, when he reviewed job descriptions provided by Kent Schaefer. Dr. Reeve stated that at that time, he felt Claimant was unable to do anything more than a sedentary type job, and the cashier and daycare worker jobs appeared to be sedentary, though he expressed concern about Claimant's ability to perform these jobs due to her educational deficits.

In reaching his opinion, it appears that Dr. Reeve had not been apprised of the fact that Claimant had worked previously as a cashier and had held various jobs before her injuries. Also, the record indicates that Dr. Reeve only saw Claimant seven times over two years. It does not appear that Dr. Reeve reviewed any of Claimant's previous medical history, other than what was reported to him by Claimant. Finally, Dr. Reeve equivocated in his opinion regarding Claimant's status. He initially reported that she had reached MMI, only to restate the same three months later. When pressed regarding whether Claimant could return to

work, he would not give a definite answer and suggested contacting Claimant's other health care providers for their opinions. In fact, he suggested contacting Tri-Life Center regarding work restrictions because they performed extensive physical and psychological evaluations on Claimant. (CX 3, p. 100).

For the above reasons, despite the fact that Dr. Reeve was Claimant's treating physician, I accept Dr. Peterson's opinion over that of Dr. Reeve. Dr. Peterson is a board certified orthopedic surgeon and former director of the Mayo Clinic Spine Center, and he conducted thorough reviews of Claimant's medical records and desk clerk job description, as well as physical examinations of Claimant. Therefore, I find that Claimant was employable as of April 25, 2002, and could have returned to her usual employment as desk clerk, which Ms. Ramirez testified remained open and available to Claimant throughout this period.

Claimant argues that she was unable to perform the duties required of her modified desk clerk assignment; however, during the hearing, Claimant testified that she would be willing to try to return to work, though she said that her back had locked up frequently in her prior position. Claimant agreed, however, she was allowed to take breaks as needed, and she performed her duties to the satisfaction of Employer. Also, Dr. Peterson approved the desk clerk duties and opined that Claimant was physically capable of performing the job 40 hours per week so long as restrictions were adhered to, including no lifting more than 20 pounds occasionally and 10 pounds frequently, no frequent or prolonged bending, squatting or kneeling, and the ability for Claimant to change positions at least once every two hours.

The only evidence not supporting Claimant's ability to return to her usual employment are Dr. Reeve's records, which, as stated earlier, tend to equivocate regarding his opinion on Claimant's employability. When Dr. Reeve finally conceded that Claimant could physically perform the duties of desk clerk on July 24, 2003, he qualified the statement by indicating that Claimant's educational deficits may hamper her ability to work. However, Claimant's work history demonstrates that she was capable of such employment. She has in the past worked as a cashier, desk clerk, waitress and housekeeper. No problems regarding her mental abilities were noted as affecting her work performance as a desk clerk. Finally, the vocational rehabilitation specialists who reviewed her academic test scores all opined that she was capable of performing as a desk clerk, save for the OWCP counselor who stated that Claimant needed a job where she could learn information at her own pace.

Consequently, I find that Claimant's inability to perform the desk clerk position at Employer's facility after April 25, 2002 was due to her own act of relocation, and that Claimant has not demonstrated that she was incapable of returning to her former desk clerk position with regard to either the physical or mental requirements of the position. Further, even if Claimant could establish a prima facie showing that she could not return to her usual employment, Employer has demonstrated the availability of suitable alternative employment.

In this instance, Employer not only showed that Claimant's former position as desk clerk remained available had she chosen to return, Employer also established that there was suitable alternative employment in Minot, North Dakota. Based on the restrictions contained in Dr. Peterson's IME, Kent Schafer conducted a labor market survey in Minot and located jobs that Dr. Reeve on January 24, 2003 interpreted as sedentary which was the only type of job he thought Claimant could physically perform. Dr. Peterson also approved six of the eight jobs located in Minot on December 16, 2002.

In the instant case, based on Drs. Peterson's opinion, Claimant would have been physically able to perform most of the jobs identified by Mr. Schafer. Specifically, Claimant would have been able to be a lodging clerk or cashier at Minot Air Force Base earning $5.15 per hour, or gas station cashier, convenience store cashier, hotel front desk clerk, or sewing machine operator, earning $6.00 per hour. Claimant also could have returned to her previous employment where it was testified she could have earned $8.50 per hour. All jobs would have adhered to Dr. Peterson's lifting restrictions and would have allowed Claimant to sit or stand for most of the day as needed. In sum, I find that Claimant was employable as of April 25, 2002, and has not established that she could not return to her previous position with Employer, a job she did not return to of her own volition and which paid wages equal to or greater than her pre-accident wage.

A final issue regarding Claimant's disability upon which the parties disagree involves her entitlement to benefits during her participation in Tri-Life's pain management program. Because this program was recommended by both Drs. Reeve and Peterson, and because it was a full-time program, I find that Claimant was precluded from earning any wages at that time and therefore reverted to total disability status for the three-week period of January 27, 2003 through February 14, 2003.

Medicals

In order for a medical expense to be assessed against the employer, the expense must be both reasonable and necessary. *Parnell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979). Medical care must be appropriate for the injury. 20 C.F.R. § 702.402. A claimant has established a prima facie case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work related condition. *Turner v. Chesapeake & Potomac Tel. Co.,* 16 BRBS 255, 257-258 (1984). The claimant must establish that the medical expenses are related to the compensable injury. *Pardee v. Army & Air Force Exch. Serv*., 13 BRBS 1130 (1981). *Suppa v. Lehigh Valley R.R. Co.*, 13 BRBS 374 (1981). The employer is liable for all medical expenses which are the natural and unavoidable result of the work injury, and not due to an intervening cause. *Atlantic Marine v. Bruce*, 661 F.2d 898, 14 BRBS 63 (5th Cir. 1981), *aff'd* 12 BRBS 65 (1980).

An employee cannot receive reimbursement for medical expenses under this subsection unless she has first requested authorization, prior to obtaining the treatment, except in cases of emergency or refusal/neglect. 20 C.F.R. § 702.421; *Shahady v. Atlas Tile & Marble Co*., 682 F.2d 968 (D.C. Cir. 1982) (per curium) *rev'g* 13 BRBS 1007 (1981), *cert. denied*, 459 U.S. 1146 (1983); *McQuillen v. Horne Bros., Inc.*, 16 BRBS 10 (1983); *Jackson v. Ingalls Shipbuilding Div., Litton Sys.*, 15 BRBS 299 (1983); *Schoen v. U.S. Chamber of Commerce*, 30 BRBS 112 (1996). If an employer has no knowledge of the injury, it cannot be said to have neglected to provide treatment, and the employee therefore is not entitled to reimbursement for any money spent before notifying the employer. *McQuillen v. Horne Bros., Inc.*, 16 BRBS 10 (1983).

The possibility of Claimant undergoing a spinal fusion has been discussed over the years. Some physicians, such as Dr. Tung and Dr. Reeve, believe that Claimant may be a candidate for the procedure, whereas others, like Dr. Peterson and Dr. Davidson, disagree. It is unclear from the record whether Claimant herself wants this procedure performed. The surgery has not been scheduled, is not a definite occurrence in the foreseeable future, and accordingly, I will not pass on the issue at this time.

As to the pain management program, Employer argues that Claimant's follow-up appointments with Tri-Life Center were not authorized and therefore not compensable. Claimant argues that her injuries were work related and the treatment provided was both reasonable and necessary.

Both Drs. Reeve and Peterson stated that Claimant could benefit from a pain management program. The three week Tri-Life program was approved by Carrier on January 23, 2003. Claimant completed the Tri-Life program and appeared to derive some benefit from it, according to herself and Dr. Reeve. Claimant attended the customary six follow-up visits, but these visits were not authorized by Carrier. However, despite the fact that the visits were not expressly authorized, it is apparent that Carrier was aware the visits were occurring, as Tri-Life sent copies of reports and appointment dates to Carrier. The follow-up visits are also described in the initial contract signed by Claimant. Therefore, because Drs. Reeve and Peterson both agreed that the pain management program was reasonable and necessary, Claimant is entitled to such. The six follow-up visits are a standard part of the program, and Employer was aware that the visits were occurring. Employer is responsible for these expenses.

Claimant has also requested honoring the recommendation made by Tri-Life's treatment team for Claimant's medications to be monitored by a physician. Dr. Peterson agreed that this recommendation was appropriate, given the amount of medication Claimant is currently taking. Therefore, I find that this recommendation is reasonable and necessary in light of Claimant's ongoing treatment and therefore, it is covered by the Act.

Average Weekly Wage

Section 10 sets forth three alternative methods for determining a claimant's average annual earnings, which are then divided by fifty-two, pursuant to Section 10(d), to arrive at an average weekly wage. 33 U.S.C. § 910(d)(1). The computation methods are directed towards establishing a claimant's earning power at the time of the injury. *Johnson v. Newport News Shipbuilding & Dry Dock Co.*, 25 BRBS 340 (1992); *Lobus v. I.T.O. Corp.*, 24 BRBS 137 (1990).

Sections 10(a) and 10(b) apply to an employee working full-time in the employment in which she was injured. *Roundtree v. Newpark Shipbuilding & Repair, Inc*., 13 BRBS 862 (1981), *rev'g* 698 F.2d 743, 15 BRBS 94 (CRT) (5th Cir. 1983), *panel decision rev'd en banc*, 723 F.2d 399, 16 BRBS 34 (CRT) (5th Cir.) *cert. denied*, 469 U.S. 818 (1984). Section 10(a) applies if the employee worked "substantially the whole of the year" preceding the injury, which refers to the nature of the employment, not necessarily the duration. The inquiry should focus on whether the employment was intermittent or permanent. *Gilliam v. Addison Crane Co.*, 21 BRBS 91 (1987); *Eleazer v. General Dynamics Corp.*, 7 BRBS 75 (1977). If the time in which the claimant was employed was permanent

and steady then Section 10 (a) should apply. *Duncan v. Washington Metropolitan Area Transit*, 24 BRBS 133 (1990) (holding that 34.5 week of work was "substantially the whole year", where the work was characterized as "full time", "steady" and "regular") . The number of weeks worked should be considered in tandem with the nature of the work when deciding whether the Claimant worked substantially the whole year. *Lozupone v. Lozupone & Sons*, 12 BRBS 148, 153-156 (1979).

Section 10(b) applies to an injured employee who worked in permanent or continuous employment, but did not work for substantially the whole year. 33 U.S.C. § 910(b); Empire United Stevedores v. Gatlin, 936 F.2d 819, 25 BRBS 26 (CRT)(5th Cir. 1991). This would be the case where the claimant had recently been hired after having been unemployed. Section 10(b) looks to the wages of other workers and directs that the average weekly wage should be based on the wages of an employee of the same class, who worked substantially the whole of the year preceding the injury, in the same or similar employment, in the same or neighboring place. Accordingly, the record must contain evidence of the substitute employee's wages. See *Sproull v. Stevedoring Servs. of America*, 25 BRBS 100, 104 (1991).

Neither 10(a) nor 10(b) is appropriate because there is insufficient evidence to properly use the calculations mandated by these sections. Without the number of days Claimant worked, nor the wages of comparably situated co-workers, it is imperative to calculate the average weekly wage under the auspices of 10(c).

Section (c) is a catch-all to be used in instances when neither (a) nor (b) are reasonably and fairly applicable. If employee's work is inherently discontinuous or intermittent, her average weekly wage for purposes of compensation award under Longshore and Harbor Workers' Compensation Act (LHWCA) is determined by considering her previous earnings in employment in which she was working at time of injury, reasonable value of services of other employees in same or most similar employment, or other employment of employee, including reasonable value of services of employee if engaged in self-employment. Longshore and Harbor Workers' Compensation Act, §§ 10(c), 33 U.S.C.A. §§ 910(c). *New Thoughts Finishing Co. v. Chilton*, 118 F.3d 1028 (5th Cir. 1997).

August 31, 1997 Accident

In this case, Claimant and Employer are in agreement that 10(c) is the appropriate method by which to calculate Claimant's average weekly wage. They

differ, however, on the divisor and the method of calculation. Claimant contends that the correct figure is ascertained by using her hourly rate of $6.61 per hour (an increase effective June 6, 1997) multiplied by the average number of hours she worked during the pay periods ending December 21, 1996 through July 5, 1997. Claimant excludes the period of time subsequent to July 6, 1997 that she was absent from work because she was out of state with her ill mother, resulting in a divisor of 30 weeks. During this 30 week period, Claimant worked 945.5 hours, so her average hours per week were 31.52. When multiplied by $6.61, the result is an average weekly wage of $208.25, which is added to Claimant's earnings from her employment at Target ($1,421.29, divided by 30 weeks) of a $47.38 weekly average for a total of $255.73 and a corresponding compensation rate of $200.27. Employer, on the other hand, argues that Claimant voluntarily withdrew from the labor market during the weeks ending July 19, 1997 through August 16, 1997, and that those weeks should not be excluded from the calculation. Thus, Employer contends the proper divisor is 38 weeks. I agree.

The prime objective of 10(c) is to "arrive at a sum that reasonably represents a claimant's annual earning capacity at the time of injury." *Wayland v. Moore Dry Dock*, 25 BRBS 53, 39 (1991). All sources of employment income should be considered in a fair and reasonable determination of wage earning capacity. *Id.* at 59. Furthermore, under 10(c) a claimant's actual wages should be used where she voluntarily leaves the labor market, and therefore has earnings lower than her earning capacity. To hold an employer responsible for a claimant's pre-injury removal of self from the work force would be manifestly unfair. *Geisler v. Continental Grain Co.*, 20 BBS 35 (1987); *Harper v. Office Movers/E.I. Kane*, 19 BRBS 128, 130 (1986). Here, Claimant testified that she voluntarily removed herself from the work force for eight weeks to attend to her ailing mother out of state. In keeping with the Board's precedent, Claimant's average weekly wage should reflect her actual earnings and the divisor should include the eight weeks. Consequently, I find that her total earnings should be divided by 38 weeks.

Because Claimant earned $6.61 per hour at the time of her accident due to a raise, I find it would be unfair to include a lower hourly rate in the calculation of Claimant's average weekly wage, as it would not accurately reflect what she would have earned had she not been injured. In addition, multiplying all of Claimant's hours by the rate she was paid for the last two months of her employment would not accurately reflect her earnings either. Thus, since Claimant worked a total of 989.5 hours over 38 weeks, the average number of hours she worked per week was 26. When multiplied by her hourly wage in effect at the time of injury times 52 weeks, the result is an annual earning capacity of $8936.72,

thus the average weekly wage would be $171.86 per week. When added to her earnings from Target ($1421.29 total, divided by 38 weeks) of $37.40 per week, the result is an average weekly wage of $209.26.

March 23, 2001 Accident

Regarding Claimant's March 23, 2001 injury, her payroll records indicate that she was paid a total of $5306.68 for the year before the injury, and was being paid an hourly rate of $7.54 on the date of the injury. (CX 18, p. 296). Despite the records covering a year before the accident, Claimant only worked 24 weeks in that year long period as a result of being removed from work by her physicians. In those 24 weeks, Claimant earned $2377.48, averaging 13.3 hours of work per week, resulting in an average weekly wage of $100.28.[5]

Section 14 (e) penalties

Under Section 14 (e) an employer is liable for an additional 10% of the amount of worker's compensation due where the employer does not pay compensation within 14 days of learning of the injury, or fails to timely file a notice of controversion within 14 days. 33 U.S.C. §914. In this instance, Employer paid compensation on September 5, 1997, six days after injury, and March 28, 2001, 5 days after injury. Therefore, as Employer paid compensation within 14 days of learning of injury, no § 14 (e) penalties are assessed against Employer.

ORDER

It is hereby **ORDERED, ADJUDGED AND DECREED** that:

(1) Employer/Carrier shall pay to Claimant compensation for temporary total disability benefits from September 5, 1997 until March 9, 1998 (when Claimant returned to light duty housekeeping), March 24, 1998 until April 3, 1998, May 8, 1998 through May 29, 1998, and July 28, 1998, until April 13, 1999 the

[5] Granted, this low figure seems odd in view of my earlier finding that this job amounted to suitable alternative employment at a wage equal to or greater than Claimant's pre-accident wage. The explanation is that while I here felt compelled to use Claimant's actual wage to determine her compensation, the evidence I previously relied on demonstrated that had Claimant chosen to do so, 40 hours per week had been available to her and that such a showing satisfied Employer's burden of suitable alternative employment.

date of maximum medical improvement, based on an average weekly wage of $209.26;

(2) Employer/Carrier shall pay to Claimant compensation for permanent total disability benefits from April 13, 1999 until October 24, 1999, and December 28, 1999 through March 21, 2000, when Claimant returned to suitable alternative employment, based on an average weekly wage of $209.26;

(3) Employer/Carrier shall pay to Claimant compensation for temporary total disability benefits from March 23, 2001 through March 26, 2002, the date of maximum medical improvement, based on an average weekly wage of $100.28;

(4) Employer/Carrier shall pay to Claimant compensation for permanent total disability benefits from January 27, 2003 through February 14, 2003, the period in which Claimant was enrolled in a pain management program, based on an average weekly wage of $100.28;

(5) Employer/Carrier shall pay or reimburse Claimant for all reasonable and necessary medical expenses, resulting from Claimant's injuries of August 31, 1997 and March 23, 2001;

(6) Employer/Carrier shall be entitled to a credit for all payments of compensation previously made to Claimant;

(7) Employer/Carrier shall pay interest on all of the above sums determined to be in arrears as of the date of service of this ORDER at the rate provided by in 28 U.S.C. §1961 and *Grant v. Portland Stevedoring Co*., 16 BRBS 267 (1984);

(8) Claimant's counsel shall have twenty days from receipt of this Order in which to file a fully supported attorney fee petition and simultaneously to serve a copy on opposing counsel. Thereafter, Employer shall have ten (10) days from receipt of the fee petition in which to file a response;

(9) All computations of benefits and other calculations which may be provided for in this ORDER are subject to verification and adjustment by the District Director.

Entered this 12th day of November, 2004, at Metairie, Louisiana.

A

C. RICHARD AVERY
Administrative Law Judge

CRA:bbd